Attachment 5

Appendix J—Functional Requirements Matrices

As described in the RFP, DCH requires consolidated support for all of its health benefits programs, including Medicaid, PeachCare for Kids, SHBP, and BORHP. This means, for example, that DCH requires a single application software system, including consolidated database, logic, and interfaces. As one example of this, DCH expects that the bidder will propose a single provider database for all health benefits programs. (In the event the bidder cannot propose a single system, then DCH requires that the bidder at least provide the *appearance* of a single application system using a consolidated set of web-based interfaces and open system interfaces.)

Given these key points, bidders should ultimately regard the functional requirements in this Appendix J as a single set of requirements to be met using a single application system. However, these requirements are being presented for the most part as being specific either to Medicaid/PeachCare for Kids or to SHBP/BORHP for the following reasons:

1. Clarity of Requirements: While DCH desires to foster consistency across all of its benefits programs, and indeed in many respects program administration requirements are similar across those programs, it is also the case that many specific requirements of the programs do differ. This is especially true between Medicaid/PeachCare for Kids and SHBP/BORHP (key examples include areas such as eligibility maintenance and regulatory reporting). Many of these specific differences arise from the legal and regulatory foundations of the different programs (Title XIX and XXI in the cases of Medicaid and PeachCare, and state laws in the cases of SHBP and BORHP). Given this, it is useful to describe specific requirements separately in order to fully and accurately describe the requirements pertaining to the different programs.
2. Phased Approach: Further, since Medicaid/PeachCare for Kids, SHBP, and BORHP all have different implementation dates, it is potentially useful to describe separately the requirements specific to each of these programs so that bidders can determine their approach, schedule, and staffing for making system changes over the initial three years of the contract.
3. Sources of Funding: Finally, since Medicaid and PeachCare development is 90 percent reimbursable from the Health Care Financing Administration under the Federal Funding Program, it is important to separately describe Medicaid and PeachCare requirements from SHBP and BORHP so that in the Cost Proposal (**Appendix L**) bidders are able to distinguish between Medicaid and PeachCare development costs and SHBP and BORHP development costs.

This Appendix therefore contains three separate matrices:

Matrix 1: General System Requirements that apply to all programs (See page 3);
Matrix 2: Medicaid/PeachCare for Kids Requirements (See page 18); and
Matrix 3: SHBP/BOR Requirements (See page 53).

Each matrix lists the mandatory functional requirements and desirable functional capabilities for systems supporting the DCH/BOR programs. These functional requirements may be met through a combination of automated capabilities and manual processes. For each functional requirement, indicate your proposed system's ability to meet the requirement by checking the appropriate boxes:

- Current Capability—the proposed system currently has the capability to meet the requirement.
- Future Capability—the proposed system will have the capability to meet the requirement by the required implementation phase. An explanatory statement is required in the "Comments" section. Also include a target date for this capability.
- Manual Process—the requirement will be met through a manual process. An explanatory statement is required in the "Comments" section.
- No Capability—the proposed bidder has no capability to meet the requirement. An explanatory statement is required in the "Comments" section.

As noted above, bidders are required to include explanatory comments if any of the last three responses (Future Capability, Manual Process, or No Capability) are checked. Otherwise, bidders may optionally add comments in the space provided, as necessary, to further explain their capabilities. A reference to an appendix document may be placed in the space if the comment is too long to fit in the space. Responses to the Functional Requirements grids attached will be verified during onsite visits to the bidders.
All information must be accurate as it is incorporated into the final contract by reference.

Matrix 1: General Systems Requirements that Apply to All DCH Programs

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Technical Standards (Applies to All Programs):					
1.	All databases must be relational and comply with ANSI SQL (currently ANSI SQL 93)				
2.	The application(s) is/are directory–enabled so authentication credentials can be stored in any LDAP compliant directory the agency specifies				
3.	X.509 public key certificates are supported				
4.	IP security to provide end-to-end confidentiality of packets traveling over the Internet				
5.	SSL v3 for communication between web browser and web server				
6.	S/MIME V3.0 for securing e-mail communications				
7.	Applications are able to transmit and receive messages using TCP/IP and sockets, FTP, or serial transmission				
8.	The application(s) can be managed by an SNMP-compliant management tool				
9.	Scanned images of business documents will be committed to storage in TIFF format V5.0 using CCIT/ITU Group II or IV compression				
10.	eXtensible Markup Language (XML) is supported for data exchange among applications				

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
11.	The applications will be highly modular, using a component-based architecture that supports dynamic changes to business processes. These n-tier components (such as "autopay" can be used as part of the DCH application infrastructure by other state agencies. Each n-tier component will have a published interface				
12.	Business rules will be coded in a platform neutral language (C, C++, JAVA, COBOL)				
13.	The application will be designed to separate user interface code, business rules, and data access. Multiple user interfaces (web browser, cell phone, and PDA) are supported without a second instance of the executable image of the business rules				
14.	Isolate and generalize user interfaces to support a wide range of options (browser, voice response, PDA, etc.)				
15.	Data access is independent of the physical data location				
Technical Standards Comments:					

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
System Structure and Architecture (Applies to All Programs):					
16.	Web-enabled primary interface				
17.	Web-enabled secondary interface for all HIPAA transactions				
18.	Single, electronic point of entry for all HIPAA transactions for all members and providers (for Medicaid, PeachCare for Kids, SHBP and BORHP)				
19.	Modern RDBMS (no flat file systems allowed). At a minimum, the RDBMS must meet ANSI SQL93 or equivalent standards				
20.	Ability to support real-time access to and consolidation of all healthcare data (including Medicaid, PeachCare for Kids, SHBP, and BORHP)				
21.	Online help for system users				
22.	Ad hoc reporting tools				
23.	Modern job scheduling software				
24.	Screen navigation options				
25.	Alert reminders				
26.	Work flow support for routing and tracking data among users				
27.	Imaging and OCR support for processing, storing, and retrieving text documents. To ensure compatibility, hardware and software compatibility using TWAIN or ISIS facilitate interoperation of peripherals. Also, images should be stored in standard formats, such as TIFF				
28.	Security within the network (user profiles and passwords) that meets or exceeds HIPAA privacy and security regulations				

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
29.	Security across the Internet (e.g., user profiles and passwords, level of encryption, certificates, firewalls, etc., that meets or exceeds HIPAA privacy and security regulations)				
30.	Online and batch printing				

Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
System Structure and Architecture Comments:				

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Security (Applies to All Programs):					
31.	Assigns individual system passwords that are required to access the system				
32.	Assigns individual system passwords that do not display when entered				
33.	Assigns individual system passwords that control security clearance to access specified system functions				
	Assigns individual system passwords that control security for inquiry, add, change, and delete transactions by user ID and password at the following levels:				
34.	▪ Menu				
35.	▪ Module				
36.	▪ File				
37.	▪ Record				
38.	▪ Field				
39.	Locks an individual out after three failed attempts to log onto the system; supervisor/systems area staff approval required to unlock				
40.	Auto system logoff if terminal idle for specified time period and/or end of day				

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Security Comments:					
Fraud and Abuse Detection (Applies to All Programs):					
	Provide fraud and abuse detection and review; adhere to NCCP standards. Monitor provider claims to detect patterns of:				
41.	▪ Fraud				
42.	▪ Abuse				
43.	▪ Excessive billing				
44.	▪ Inappropriate billing practices				
45.	▪ Unnecessary utilization				
46.	▪ Clinically inappropriate services				
	Employ proven database design and data management methodologies to validate, edit, scrub, and transform raw data into an "analytically ready" decision support database. Methodologies must address the following:				
47.	▪ Standardizing data into a common format to enable normative comparisons				
48.	▪ Analyzing completeness of updates based on historical and projected data volume for the source				
49.	▪ Integrating various data types and formats, such as medical claims, costs, eligibility information, and provider information				

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
50.	Ability to detect multi-level and multi-party fraud				
51.	Review capability for all types of claims, such as, but not limited to, professional claims, institutional claims, and Medicare crossover claims				
52.	Capability to provide the enhanced flexibility to query by several variables and combinations of variables, including provider, type of service, place of service, date of service, recipient, modifiers, code combinations, etc.				
	Capability to provide a wide range of statistical summaries and comparisons, and multiple identification models to detect fraud, such as, but not limited to:				
53.	▪ time series analysis				
54.	▪ anomaly detection				
55.	▪ geometric ratios				
56.	▪ acceleration rates				
57.	▪ cluster analysis				
58.	▪ regression analysis				
59.	▪ discriminate analysis				
60.	▪ artificial intelligence analysis				
61.	▪ rule-based systems				
62.	▪ similarity profiling				
63.	▪ alias detection				
64.	▪ network analysis				
65.	▪ geographic analysis				
66.	▪ focused detection algorithms				
67.	▪ fuzzy modeling				
68.	▪ user-defined algorithms				

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
69.	▪ expert system capabilities				
70.	▪ neural network technology				
71.	▪ evolutionary programming and genetic algorithms				
72.	Ability to provide reports with targeted leads to enable DCH/BOR to focus on areas where there is the greatest likelihood of high monetary return on investment				
73.	Ability to produce reports in files that can be loaded into Microsoft 2000 Access or Excel				
74.	Ability to provide technically accurate and user friendly reports that contain fraud risk scores that are concise and specific to review purposes				
75.	Ability to provide, as report attachments, charts or graphs as necessary to highlight areas on which investigative interest should be focused				
76.	Ability to report data by both provider and recipient				
77.	Ability to report by provider type and specialty				
78.	Ability to report by Medicaid eligibility group for the Medicaid recipient population				
79.	Ability to report "to the penny" balancing of financial data with claims				
	Ability to apply detailed edits, including:				
80.	▪ Provide edit for obsolete procedure codes and substitute a more appropriate code				
81.	▪ Provide edit for experimental procedures				
82.	▪ Provide edit for cosmetic or discretionary edits				
83.	▪ Provide edit for inappropriate use of modifiers				

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
84.	▪ Provide edit for procedure codes considered to be included in a major procedure				
85.	▪ Provide edit for inappropriate assistant surgery				
86.	▪ Provide edit for obstetrical global fee period				
87.	▪ Provide edit for surgical global fee period				
88.	▪ Provide edit for use of new patient code at least every three years				
89.	▪ Provide edit for use of initial IHM code or discharge visit				
90.	▪ Provide edit for critical care visit frequency				
91.	▪ Provide edit for physician visit frequency				
92.	▪ Provide edit for repeat procedures				
93.	▪ Provide edit for professional component allowance				
94.	▪ Provide edit for unbundled radiology				
95.	▪ Provide edit for mutually exclusive procedures				
96.	▪ Provide edit for post-operative and preoperative care				
97.	▪ Provide edit for medical protocol				
98.	▪ Provide edit for fragmented procedures				
99.	▪ Provide edit for secondary procedure allowance				

Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Fraud and Abuse Detection Comments:				

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
HIPAA Compliance with Transaction and Unique Identifier Standards (Applies to All Programs):					
100.	Map existing data to ASC X12N 270 Health Care Eligibility (benefit inquiry) for each data element in the system				
101.	Map existing data to ASC X12N 271 Health Care Eligibility (benefit response) for each data element in the system				
102.	Map existing data to ASC X12N 276 Health Care Status (electronic inquiry regarding claim status) for each data element in the system				
103.	Map existing data to ASC X12N 277 Health Care Status (electronic response regarding claim status) for each data element in the system				
104.	Map existing data to ASC X12N 278 Referral Certification and Authorization (response regarding claim status) for each data element in the system				
105.	Map existing data to ASC X12N 820 Health Plan Premium Payments (transfer of funds) for each data element in the system				
106.	Map existing data to ASC X12N 834 Health Plan Enrollment/Disenrollment for each data element in the system				
107.	Map existing data to ASC X12N 835 Health Care Payment/Remittance (used in conjunction with 820 regarding payment information) for each data element in the system				
108.	Map existing data to ASC X12N 837 Health Claims (Professional, Institutional, and Dental; used for claims submission) for each data element in the system				
109.	Develop transmission/translation strategies and testing process to allow the system to accept and process Transaction Standards				

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
110.	Develop error processes to identify problem areas and assist in correcting system and notifying sender that an error occurred and changes are required to process a “clean” transaction standard				
111.	Develop performance measures for acceptance and processing of a “clean” Transaction Standard				
112.	System utilizes HIPAA standard National Provider Identifier				
113.	System utilizes HIPAA standard Employer Identifiers				

HIPAA Transaction/Identifier Standards Compliance Comments:

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
HIPAA Compliance with Code Sets (Applies to All Programs):					
114.	Adhere to the use of ICD-9, ICD-10, CPT, HCPCS, NDC, CDP, and CDT-3 as required by October 2002				
115.	Assess current code sets and develop capacity to accept updated code sets as scheduled				
116.	Develop error edits to identify problems that affect clean claims processing as it relates to the code sets				
117.	Accept all code sets for processing claims based on DOS				
118.	Ability to map local procedure codes to HIPAA standard code sets				
119.	Ability to map DSM-IV diagnosis codes to ICD-9 codes				
HIPAA Compliance with Code Sets Comments:					

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
HIPAA Compliance with Privacy and Security Standards (Applies to All Programs):					
120.	Perform data mapping to identify the Protected Health Information (PHI) contained in the system and electronically transfer in order to perform HIPAA business functions				
121.	Perform a risk analysis and develop a strategic plan to eliminate or reduce risks				
122.	Develop policies and procedures identifying security measures taken to protect PHI				
123.	Implement audit trails to monitor PHI received; identify format, access, and purpose for use and test against policies				
124.	Review Business Partner and Chain of Trust Agreements with existing contracts for HIPAA compliance				
HIPAA Compliance with Privacy and Security Standards Comments:					

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Systems Documentation:					
	Maintain and provide documentation that is current, comprehensive, and reflects actual operation. Documentation list includes, but is not limited to:				
125.	▪ Programming documentation				
126.	▪ Systems design documentation				
127.	▪ Computer operations documentation				
128.	▪ User documentation				
129.	▪ Organizational documentation				
130.	Systems change requests are fully documented and tracked				
131.	Provide a system/process for tracking system enhancements or modifications				
132.	All data is maintained in relational databases				
133.	Provide GUI user interface to system for DCH operational staff				
134.	Support MS-Windows environment for all online user access				
	Create and provide access to a data repository that contains, at a minimum:				
135.	▪ Adjudicated claims data				
136.	▪ Suspended claims data				
137.	▪ Adjustment/voided claims data				
138.	▪ Financial transactions				
139.	▪ Reference database				
140.	▪ Provider database				
141.	▪ TPL data, including cost avoidance interface with the TPL vendor				
142.	▪ Member database				

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
143.	Provide capability to use the data repository for report and data extraction as requested				
144.	Create and maintain a comprehensive data dictionary for system				
145.	Ability to archive data by parameters defined by the State				
146.	Provide audit trails for updates to all databases				
147.	Maintain a test environment which will mirror the production environment				
148.	Maintain five years of claims history, provider, member, reference, and third party resource data on line				

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Systems Documentation Comments:					
Auto Audit Requirements (Applies to All Programs):					
149.	Ability to utilize the National Correct Coding Initiative (NCCI) edits for bundling/unbundling of codes per recipient/provider and date of service.				
150.	Update NCCI edits on a quarterly basis				
151.	Use of date sensitive NCCI edits				
152.	Capability of utilizing at least two modifier fields for edit placement				

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
153.	Ability to develop and produce DCH specific reports to evaluate effectiveness of edits				
154.	Produce reports that include information relating to the savings realized due to the edits				
155.	Produce edit-specific reports for each category of service for each claims payment cycle				
156.	Capability to produce reports in a soft copy format (Access or Excel)				
157.	Ability to customize edits to DCH specifications				
158.	Ability to lock-in or lock-out providers by specialty through edits as determined by DCH				
159.	Ability to implement customizations or changes requested by DCH in a timely manner and accomplishable at any time				
160.	Ability to customize edits by a Plan level (i.e., general characteristics such as age or sex) as defined by DCH				
161.	Ability to customize edits by procedure/diagnosis code				
162.	Ability to customize edits by limitations (i.e., weekly, monthly, yearly)				

Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Auto Audit Requirements Comments:				

	Matrix 1 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
System Service Request Tracking (Applies to All Programs):					
163.	Ability to document systems change/enhancement requests and problems and generate a record of the issue for automated tracking from identification through resolution and documentation update as required				
	Ability to capture and record pertinent information related to issues being tracked, including:				
164.	▪ Issue/problem description				
165.	▪ Severity indicator				
166.	▪ Requested resolution/implementation date				
167.	▪ Estimated level of effort required				
168.	▪ Client approval of specifications				
169.	▪ Client approval of time estimate				
170.	▪ Turnover date for user acceptance testing				
171.	▪ Client sign-off on user acceptance test results				
172.	▪ Vendor finalization of user/design documentation				
173.	▪ Client sign-off on completion				
174.	Ability to generate weekly progress reports of the status of each system service request in process				
Service Request Tracking Comments:					

Matrix #2: Medicaid/PeachCare Requirements

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Provider Relations Management:					
1.	Process provider enrollment applications submitted via paper				
2.	Process provider enrollment applications submitted via the Internet				
3.	Verify licensure and certification credentials and assign unique provider identification numbers, based on HIPAA standards				
4.	Cross-reference/track all relevant provider numbers such as Medicare provider number, NPI, CLIA number, license number, SSN, FEIN, NBP, DEA, etc.				
5.	Maintain a provider database that will accommodate all of the providers in the Georgia Medical Assistance Program (GMAP) network				
6.	Maintain a provider database that utilizes sophisticated editing to avoid duplication of provider records				
7.	Maintain a provider database that utilizes sophisticated editing to guarantee data integrity and accuracy through the application of user-defined edits for presence and valid field values				
8.	Maintain provider history that will record changes to licenses, names, locations, or actions; all changes must be marked with begin and end dates				
9.	Maintain a provider database that will have the ability to lock in or lock out providers to specific diagnosis codes, procedure codes and modifiers				
10.	Support required provider network reporting				
11.	Generate reports on demand to evaluate the provider network				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
12.	Generate reports and supporting documentation on demand to support DCH in provider grievance hearings and appeal processes				
13.	Generate mailings to selected providers based on user-defined criteria or by specified data fields				
14.	Generate provider mailings via e-mail or FAX				
15.	Ability to select providers by zip code, provider type, provider specialty, program participation, and other user-defined criteria				
	Upload and apply changes to the provider database from multiple external sources based on user specifications. Examples of databases are:				
16.	▪ Provider organizations				
17.	▪ State of Georgia				
18.	▪ HCFA				
19.	▪ CLIA Oscar file				
20.	▪ Licensure and certification files				
21.	Maintain agreements for billing agencies using electronic claim submissions				
22.	Maintain a provider database that will accept group provider numbers and relate and cross-reference individual providers to their groups				
23.	Maintain a provider database that will identify the out-of-state providers				
24.	Maintain a provider database that will allow multiple names, addresses, and telephone numbers for a provider				
25.	Maintain a provider database that will track number of beds and level of care for institutional facilities				
26.	Generate provider enrollment approval or denial letters				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
27.	Generate 1099 notices and associated payment reports				
28.	Support telephone inquiries from providers after hours through an automated voice response system				
29.	Create a provider enrollment process and track provider applications through the approval process				
30.	Ability to check enrollment status, deficient documentation listings, etc, via the web				
31.	Generate data extracts from the provider subsystem on request				
32.	Ability to generate user-specified correspondence to all or selected providers				
33.	Automatically generate letters to providers regarding the provider enrollment process, and where they are in the process				
34.	Maintain a database that will record and track provider credentialling data and credentialling processing status				
35.	Interface with claims processing modules to perform required editing				
	Communicate with providers through multi-channel communications:				
36.	▪ Web pages/Internet				
37.	▪ Call centers				
38.	▪ Computer integrated telephony				
39.	Allow provider to access own records via the web				
40.	Allow provider to access member eligibility data via the web				
	Track all inquiries, applications, requests for assistance, and requests for changes and, at a minimum, document the following:				
41.	▪ Initial contact date				
42.	▪ Contact source				
43.	▪ Actions taken by the subcontractor				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
44.	▪ Resolution of the issues				
45.	Assign a unique provider identification number for each enrolled provider				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
	Maintain a provider database that contains the minimum data set prescribed by Part 11 of the State Medicaid Manual, including, but not limited to the following data elements:				
46.	▪ Provider name				
47.	▪ Corporate name				
48.	▪ Provider type				
49.	▪ Addresses and type of address, including location, payee and mailing addresses				
50.	▪ Phone numbers and type of phone number, including fax number				
51.	▪ Contract persons and their roles				
52.	▪ Service locations				
53.	▪ Payee TIN information–FEIN or social security number				
54.	▪ Application and enrollment dates				
55.	▪ Enrollment status				
56.	▪ Qualifications (i.e., current licenses held, Board Certifications, and specialties)				
57.	▪ Services offered, by service location				
58.	▪ Affiliations with groups, clinics, hospitals, HMOs or other organizations				
59.	▪ Designated payees				
60.	▪ Service coverage areas				
61.	▪ Provider specific rates				
62.	▪ Information on contracts or agreements specific to the provider				
63.	▪ Languages spoken at each service site				
64.	▪ Primary language spoken and understood by the provider				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
65.	▪ TDD/TTY capabilities for hearing impaired providers				
66.	▪ Name of billing agent				
67.	▪ Name of owner(s) of enrolled entity				
68.	▪ Social security number of provider or owner(s)				
69.	▪ Date of birth of provider or owner(s) of entity				
70.	▪ Georgia Better Health Care (PCP) Program number				
71.	▪ Provider status code				
72.	▪ Enrollment status code				
73.	▪ Suspense flag				
74.	Ability to add new data elements fields to the provider database on request				
75.	Track the numbers of provider inquiries, the nature of each inquiry, and the disposition of the inquiry				
76.	Generate provider correspondence and inquiry responses				
77.	Ability to track HEALTH CHECK eligible providers				
78.	The subcontractor will respond to inquiries regarding the status of claims submitted by providers via the Internet				
79.	Provide a voice response phone system for providers payment inquiries				
80.	Maintain a record of provider contacts for a minimum of two years				
81.	Develop or adapt training materials and audio visual supports required to conduct training of providers at a professional level				
82.	Maintain a registry of certified nurse aids				
83.	Provide on-line inquiry and real time update capability (i.e., add, change, delete) to the provider database				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
84.	Ability to track and report provider information history				
85.	Provide for automated updates to provider rates				
86.	Ability to enroll a provider under multiple categories of service				
87.	Ability to track and report temporary licenses				
88.	Verify via an interface with the Georgia Composite State Board of Medical Examiners that physicians have current and valid Georgia State Medical licenses				
89.	Ability to track and report physician Drug Enforcement Administration number (DEA#)				
90.	Identify and maintain data regarding types of certification/accreditation/specialty for each provider				
91.	Provide automated interface with all licensing entities for verification of licensure for new providers				
92.	Provide automatic update of license renewal data				
93.	Provide and maintain an indicator to identify providers who are tax exempt				
94.	Ability to track and report convictions and findings of patient abuse, and adverse findings				
	Ability to generate reports on providers by county and aggregate statewide by:				
95.	▪ Location				
96.	▪ Provider type				
97.	▪ Specialty				
98.	▪ Category of service				
99.	▪ Status Code				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
100.	Capability to request and access on-line provider enrollment statistics such as enrolled providers by category of service, provider type, provider specialty, etc.				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
101.	Provide automated voice response (AVR) and an Internet-based Eligibility Verification System (EVS) for provider inquiry available 24 hours per day, 7 days per week				
102.	Provide an Internet application for nursing facilities and other providers to inquire on the certification status of nurse aides, 24 hours per day, 7 days per week				
103.	Provide an Internet application for the public to report patient abuse or adverse findings, 24 hours per day, 7 days per week				
	Provide an automated Certified Nurse Aide Registry, which must at a minimum be able to:				
104.	▪ Uniquely identify each certified nurse aide;				
105.	▪ Capture demographic information for the nurse aide and maintain a record of recertification dates				
106.	▪ Capture and maintain continuing education course hours obtained for the nurse aide				
107.	▪ Generate a certification card for nurse aides				
108.	▪ Generate a duplicate certification card				
109.	▪ Generate a letter or other type of unique identifier to nursing facilities and other health care providers to verify the certification of the nurse aide				
110.	▪ Maintain and track convictions and findings of patient abuse, adverse findings, etc. by nurse aides				
111.	▪ Provide system production reports regarding the Nurse Aide Training Program, Nurse Aide Registry, and other data as designated by DMA within time frames designated by DMA				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
112.	Provide access to on-line procedures, general instructions, claims resolution examples, and sample responses to assist inquiry, including updates regarding current system problems and in-process correction and modification				
113.	Provide monthly reports to DCH regarding inquiry system activity				
114.	Provide access to procedure/operation manuals on-line				
115.	Provide the capacity to pay the certified match share of claim payment when another entity holds the "state funds"				
116.	Capability to suppress printing of any automated notices for individual providers				
117.	Capability to enroll providers as non-Medicaid; information only providers for purposes of enrollment as a member of a managed care network				
118.	Ability to research providers on the National Provider Database				
119.	Ability to access national databases for background checking of physicians prior to their enrollment in the Medicaid program				
120.	Provide on-line weekly and monthly summary reports of activity related to inquiries regarding payment procedures				
121.	Record, research, and respond to complaints from providers				
122.	Provide an automated call distribution (ACD) and reporting system to monitor the incoming and outgoing telephone calls				
123.	Ability to track and report payables and receivables by provider				
124.	Prepare and distribute a provider bulletin to notify providers of the names of the provider representatives and procedures for contacting the provider representatives				

Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Provider Relations Management Comments:				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Member Services Management:					
125.	Maintain a member database that contains member demographic data as specified by state and federal reporting requirements; at a minimum, it must contain the minimum data set defined in Part 11 of HCFA's State Medicaid Manual				
126.	Ability to enter and update member eligibility data on-line on a real time basis				
127.	Upload PeachCare eligibility data from DHACS				
128.	Maintain a member database that can support multiple eligibility groups				
129.	Maintain a member database that can support multiple eligibility categories for each member and can apply an eligibility hierarchy as defined by DCH				
130.	Maintain a member database that will assist DCH with all reporting requirements by allowing flexible user-defined query capability				
131.	Maintain a member database that will track other insurance information				
132.	Provide a member database that will track all changes by date and maintain the history of all changes by member				
133.	Maintain a member database that will track beneficiary information				
134.	Provide online inquiry capability to the member database; inquiry screens must show multiple categories of eligibility and all date periods				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
135.	Provide mnemonic name search capability on online member inquiry screens				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
136.	Maintain a member database that will assign a single unique number to an individual, as specified by the State. Once a member is assigned a number, that number shall be used for all information for that member, regardless of enrollment and terminated enrollment activity				
137.	Ability to cross-reference member SSN(s) and other insurance numbers using Master patient Index (MPI) technology				
138.	Provide sophisticated editing that will not allow duplicate member records to be created				
139.	Provide enrollment/terminated enrollment tracking and reporting on the member database; enrollment and terminated enrollment capability may be retroactive				
	Upload and apply updates to the member eligibility database from a variety of sources, as requested by user. Examples of files that may need to be uploaded are:				
140.	▪ Social Security Administration (SSA) State Eligibility Verification System (SEVS) and State On-Line Query (SOLQ)				
141.	▪ BENDEX				
142.	▪ Beneficiary Earning Exchange Record (BEER)				
143.	▪ Generate via electronic interface, Medicare Buy-In and BENDEX response transactions to SSA and HCFA, within the timeframes specified by federal regulations				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
144.	▪ Qualified Medicare Beneficiary (QMB) Outreach				
145.	▪ Other state agencies (i.e., DOAS)				
146.	▪ Department of Human Resources (DHR) (daily files) from the Dept of Administrative Services (DOAS) system				
147.	▪ Third Party Liability (TPL) recovery vendor				
148.	▪ Other insurers, as needed				
149.	▪ Other vendors, as needed, i.e., HCFA Medicare Part A/B Billing Files				
150.	Ability to reconcile member records that fail edits during the upload process. Also, research and correct pended eligibility update transactions that fail edits				
151.	Ability to track and report rejected eligibility transactions				
152.	Provide indicators in the member database for multiple categories and coverages, including, but not limited to, TPL, QMB, Qualified Disabled Working Individual, and Specified Low Income Medicare Beneficiary (SLMB)				
153.	Maintain benefit limitation status by member for reporting and inquiry				
154.	Support data extracts and online queries for individual member eligibility query				
155.	Support data extracts for tape matches with other state agencies				
156.	Support data extracts for tape matches with other insurers				
157.	Support data extracts and online queries for eligibility redetermination and status by other state agencies				
158.	Support eligibility verification or inquiries via the Internet				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
159.	Provide monthly operational reports about the number of member inquiries performed, include average waiting time, call abandonment rate, and average time per call; provide breakouts by type of calls and number of hits for inquiries				
160.	Generate electronic and paper rosters of members by program and in aggregate				
161.	Interface with claims processing software to perform appropriate editing				
162.	Provide list of members enrolled/terminated enrollment in Hospice program, by provider				
163.	Provide list of members enrolled/terminated enrollment in Swing Bed program, by provider				
164.	Provide list of members enrolled/terminated enrollment in Pre-Admission Screening Annual Resident Review (PASARR) program, by provider				
165.	Provide list of members by eligibility category				
166.	Provide list of members by special populations				
167.	Provider ad hoc member reporting as requested				
168.	Update, maintain, and allow online access to Medicare Part A and Part B buy-in information by member				
169.	Generate monthly extract for capitation payment system				
170.	Receive online updates to eligibility data				
171.	Generate Plastic Identification or Smart Card member identification cards per user-defined specifications				
172.	Ability to track and report on members by aid category				
173.	Provide reports, on request, to support the State in member grievance and appeal processes				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
174.	Enable members to access to their own eligibility data via the Internet				
175.	Enable members to access data via call center technology such as CTI, Voice Response Inquiry, etc.				
176.	Maintain member policies and procedures in electronic format				
177.	*Maintain member eligibility and demographic information*				
178.	Generate automated member correspondence				
179.	Ability to suppress generation of beneficiary identification documents for confidential services, on request				
180.	Ability to enroll and terminate the enrollment of members in managed care programs–currently this includes the Georgia Better Health Care program				
181.	Ability to track and report newborn members				
182.	Ability to detect and notify other subcontractors or DCH of suspected fraud and abuse activity				
183.	Ability to track all system generated member correspondence				
184.	Ability to provide member correspondence on behalf of the GBHC program–if required by DCH				
185.	Ability to notify members of PCP assignment				
186.	Ability to notify members of MCO assignment				
187.	Ability to enter into the system for emergency eligibility for members on request				
188.	Ability to offer TDD/TTY inquiry system for the hearing				
189.	Provide online access for inquiry regarding HEALTH CHECK eligibility and GBHC providers				
190.	Ability to refer HEALTH CHECK members to eligible providers				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
191.	Track, record and maintain data on all HEALTH CHECK referrals for diagnosis and treatment and as necessary to produce the HCFA 416 reports				
192.	Ability to track and report on HEALTH CHECK members				
193.	Ability to track and report on HEALTH CHECK service utilization				
194.	Ability to download and maintain previous EPSDT screening history via an interface with an Immunization Tracking Registry				
195.	Maintain a matrix of the EPSDT screening sequences in order to project when the next screen due and accordingly generate notices for members				
196.	Monitor appointment scheduling and mail appointment reminders to HEALTH CHECK members or their guardians prior to scheduled appointments				
197.	Generate a roster containing the screening status of each assigned member under the age of 21				
198.	Track, record and maintain data on all HEALTH CHECK appointment notices mailed to eligible members and providers				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
	Provide monthly reports on HEALTH CHECK appointment scheduling, referral appointments. The reports must document the following activities:				
199.	▪ Methods of informing new eligibles				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
200.	▪ Methods used to encourage participation of non-participating eligibles				
201.	▪ Community outreach activities				
202.	▪ Provider enrollment by county				
203.	▪ Provider address and directions				
204.	▪ Specialty				
205.	▪ Availability for screening services, time, days, hours				
206.	▪ Provider limitations, such as the number of eligible children the provider will accept				
207.	▪ Number of appointments scheduled				
208.	▪ Number and rate of appointments not kept by members				
209.	▪ Number of referral appointments identified by type of referral, such as hearing evaluation, surgical, laboratory				
210.	▪ Timeliness of referral appointments				
211.	Ability to track and report the number of screening appointments due				
212.	Ability to track and report the number of screening appointments made				
213.	Ability to track and report the number of follow-up appointments kept				
214.	Ability to generate surveys to members upon request				
215.	Ability to record, track, and report on voluntary and involuntary terminated enrollments from the GBHC program				
216.	Ability to auto-assign members to providers for the GBHC program				
217.	Ability to override the automatic enrollment decisions				
218.	Ability to retroactively enroll newborns in the same plan as their mothers				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
219.	Produce a PCP listing by area and county for members				
220.	Generate, via electronic means, member eligibility status and redetermination lists to other state agencies				
221.	Provide access to member data to all authorized Georgia state agencies via the Georgia Online Network (GO NET)				
222.	Update, maintain, and allow online access to current and historical Medicare Part A and Part B Buy-In information				
223.	Ability to update the member LTC records via online real time				
224.	Ability to add hospice members (residing in nursing facilities) to the member database(s) with their associated patient liability segments				
225.	Ability to lock-in members to specific providers, hospitals, pharmacies, capitated programs, or other services				
	Provide the capability for the Member database to interface with the following reports and files:				
226.	▪ Payment processing files				
227.	▪ TPL database				
228.	▪ Standard Management Reporting/Federal Reporting				
229.	▪ Utilization Management and Fraud and Abuse Detection				
230.	▪ EPSDT				
231.	▪ Provider files				
232.	▪ Reference files				
233.	▪ Service limitation files				
234.	▪ Ad Hoc reporting				
235.	▪ Member appeals				
236.	▪ Quality Management and Improvement /Disease Management file				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
237.	Produce audit trail of all ID cards produced and all on-line real time updates made				
238.	Produce audit trail of all inquires (online) made of SSA, SDX and BENDEX data				
239.	Ability to automatically generate all standard and routine member correspondence				
240.	Produce necessary notices, letters, and reports to support the SSI termination “ex-parte” process				
241.	Automatically generate “Certificate of Coverage” correspondence that notifies terminated members of past periods of Medicaid eligibility				
242.	Provide on-line inquiry access to the correspondence file				
243.	Ability to support mass enrollments and terminated enrollments of members from plans, GBHC assignment, etc.				
244.	Receive and process notices of member lock-in to specific providers, hospitals, pharmacies or other services				
245.	Maintain a minimum of five years of member eligibility history on-line				
246.	Perform file purges of inactive member data as defined on a regularly scheduled basis. Archive purge data for retrieval if necessary				
247.	Process member date of death information and post to member eligibility and demographic records				
248.	Reconcile overlapping eligibility records and determine precedence for eligibility categories				
249.	Track, record and maintain data on all screening, rescreening and transportation services				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
250.	Develop and maintain a network of medical and agency referral sources for a variety of needs including early intervention services for children from birth to age three who are physically or mentally disabled and at risk for growth and developmental delays				
251.	Track, record and maintain data on all referral appointment assistance requests received from providers				
252.	Maintain a referral database with updates from multiple sources to include all referral sources				
253.	Ability to report and query referral database by referral source and date received				
254.	Ability to update referral database on line real time				
255.	Update and maintain the recipient first-day liability amount for medically needy eligibles				

Member Services Management Comments:

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Claims Processing:					
256.	Accept standardized claims formats for processing				
257.	Accept UB-92				
258.	Accept HCFA 1500				
259.	Accept ANSI X12 837				
260.	Accept American Dental Association standard claim form				
261.	Accept claims in multiple media				
262.	Accept files from Medicare intermediary for cross-over billings				
263.	Process claims received from Medicare intermediary in the same manner as other provider submitted claims				
264.	Log claims tapes and diskettes upon receipt				
265.	Assign a batch number to all claims tapes, diskettes, and paper claims				
266.	Establish balance and control procedures to ensure that all claims are processed				
267.	Return Medicare cross-over claims to provider electronically				
	Accept required attachments for claims adjudication, including:				
268.	▪ Medicare Explanation of Benefits (MEOB)				
269.	▪ Accident forms				
270.	▪ Other insurer remittance advices/EOBs				
271.	Upload provider claim data from paper claims using OCR/Imaging technology				
272.	Upload TPL data from vendor				
273.	Upload Medicare premium payment data				
274.	Provide claims adjudication				
275.	Provide online adjudication for claims submitted via the Internet				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
276.	Process all claims in compliance with state and federal requirements for timeliness and accuracy				
277.	Adjudicate all claims as either approved or denied, except for services identified by DCH as pending for review				
278.	Allow DCH staff access to claims processing subsystem and provide claims review capability				
279.	Process claims for multiple providers on one invoice				
280.	Process claims adjustments; maintain the original claim and link all adjustments to it in history; re-edit and re-price each adjustment claim				
281.	Provide an automated mass adjustment capability				
282.	Provide an automated retroactive rate adjustment capability				
283.	Process voided claims requests				
284.	Track suspended claims through resolution or void request				
285.	Provide ability to process adjustments, recoupments, and voids retroactively, for up to five years				
286.	Provide appropriate and sophisticated editing of claims, as defined by the user				
287.	Provide duplicate claim checking, including potential duplicates				
288.	Provide edit for insufficient data				
289.	Provide edit for invalid data				
290.	Provide edit for required data				
291.	Provide edit for other coverage				
292.	Provide edit for invalid services				
293.	Provide edit for invalid provider				
294.	Provide edit for invalid recipient				
295.	Provide edit for timely filing				
296.	Provide edit for invalid diagnosis				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
297.	Provide edit for exceeding benefit limits				
298.	Provide edit for unauthorized services				
299.	Provide edit for denying payment of services that are capitated				
300.	Provide edit for payment of services that are “carved out” of the capitation payment				
301.	Provide edit to ensure that all required attachments have been received				
302.	Provide edit for newborn eligibility				
303.	Provide edit for co-payments				
304.	Provide audit limits, as defined by user				
305.	Provide cross check of payments				
306.	Utilize TPL data in claims processing editing and pricing				
307.	Assign each claim a unique reference number (Cash Control Number)				
308.	Ability to use hierarchical claims editing process. Report all errors for a claim (do not limit or stop editing due to failure of previous edit)				
309.	Track claims through the adjudication process from receipt through final disposition				
310.	Maintain claims processing history				
311.	Provide software to the providers for electronic submission of claims				
312.	Provide training and assistance in the installation and use of the software				
313.	Ability to report override codes and prior approval codes separately in the MMIS and SURS systems				
314.	Override claim edits and audits in accordance with State-approved guidelines				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
315.	Process claims with procedure codes and modifiers, where appropriate				
	Maintain a prior authorization (PA) database that contains, at a minimum:				
316.	▪ Unique PA number				
317.	▪ Ordering provider				
318.	▪ Rendering provider				
319.	▪ Effective dates				
320.	▪ Status code				
321.	▪ Authorized amount of service				
322.	▪ Service description				
323.	▪ Dollar amount of authorized service				
324.	▪ Dollar amount used and remaining				
325.	▪ Amount of service used and remaining				
326.	Upload and apply changes in authorizations from the appropriate vendor				
327.	Update authorization/precertification file as claims are paid to show number of units used and amount paid				
328.	Provide online update and creation of service authorizations				
329.	Research problem claims for adjudication				
330.	Log and track all out-of-state claims				
331.	Retain complete records of all claims activity for up to five years from the date of the initial paid claim				
332.	Provide professional guidance regarding claims collection, adjudication, and reporting procedures				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
	Provide fraud and abuse detection and review; adhere to NCCP standards. Monitor provider claims to detect patterns of:				
333.	▪ Fraud				
334.	▪ Abuse				
335.	▪ Excessive billing				
336.	▪ Inappropriate billing practices				
337.	▪ Unnecessary utilization				
338.	▪ Clinically inappropriate services				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Claims Processing Comments:					
Claims Payment:					
339.	Price claims using multiple payment methodologies, as appropriate and according to user-defined parameters				
340.	Ability to price claims against user-defined fee schedules				
341.	Ability to price certain procedures on a per diem basis by DRG				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
342.	Ability to price capitated claims				
343.	Deduct patient liability amounts when appropriate				
344.	Deduct TPL and Medicare paid amounts as appropriate				
345.	Ability to systematically bill all available coverage in order of benefit determination				
346.	Edit billed charges for reasonableness (low and high) and report/flag exceptions				
347.	Identify allowable reimbursement for claims according to date-specific pricing criteria, as determined by the State				
348.	Provide ability to hold payment, per user-defined situations, for individual claims, all claims processed, or all claims for a particular provider				
349.	Provide EFT payment to providers				
350.	Generate and distribute remittance advices to providers electronically				
351.	Generate and distribute remittance advices to providers in hard copy when requested				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
	Generate remittance advice to provider that includes:				
352.	▪ Itemization of submitted claims that were paid, denied, adjusted, or voided				
353.	▪ Itemization of all financial transactions				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
354.	▪ Itemization of all error conditions detecting for claims that were suspended or denied				
355.	▪ Adjusted claim information				
356.	▪ Itemizations for all DCH benefit programs including payments made via Medicaid, PeachCare for Kids, SHBP and the BORHP				
357.	Maintain controls to track each financial transaction				
358.	Maintain provider accounts showing claims paid month to date and year to date by DCH benefit plan				
359.	Ability to maintain credit balances and provide reports on providers with credit balances				
360.	Provide an automated recoupment process				
361.	Maintain a process to adjust provider 1099 reports after recoupment processing				
362.	Provide override capability of recoupment and adjustments under strict security; allow entry of comments to explain the action taken; maintain an audit history of such actions				
363.	Track provider credit balances				
364.	Respond to provider overpayments by adjustments or void of paid claim				
365.	Process manual payments in unusual or emergency situations				
366.	Generate provider checks if necessary				
367.	Maintain accounts receivables and report on activity				
368.	Accurately withhold nonfederal share of claims paid for those providers designated by the State in cases where the State share is available from another source				
369.	Ensure payment reporting accurately reflects total expenditures for those claims where the nonfederal share was withheld				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
370.	Provide capability to handle multiple capitation rates for different programs, different combinations of members, and different geographic regions				
371.	Generate one monthly capitation payment to each provider that covers all members enrolled and eligible by that provider for the GBHC program				
372.	Produce system-generated remittance advices to GBHC providers to list all members covered by the monthly capitation payment				
373.	Produce an online report detailing all refunds by check number, date, claim control number, and deposit number				
374.	Provide online summaries of transactions processed and account balances				
375.	Copy and store all checks/EFT payments using document imaging and workflow technology				
376.	Implement a cash flow management system allowing the system to hold payment of a claim for a specified period of time, as defined by the State				
377.	Execute payment claims; payment cycles weekly or biweekly as specified by DCH				
378.	Provide claims aging reports				
379.	Generate automated responses to requests for information on payment procedures by providers, carriers, or other interested parties				
380.	Ability to interface with State financial reporting system (PeopleSoft)				

Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Claims Payments Comments:				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Reference File Maintenance:					
381.	Maintain all reference file data history. Must be maintained for a minimum of ten years				
382.	Provide effective begin and end dates for all reference file data elements that require date specific actions, such as online edits, claims edits, and reporting				
383.	Provide online inquiry for designated DCH staff to all reference file databases				
384.	Provide editing as needed to support referential and data integrity in all reference databases				
385.	Update all reference databases on an approved schedule with at least 99 percent accuracy				
386.	Upload and apply updates to CPT-4 procedure codes				
387.	Upload and apply updates to HCPCS				
388.	Upload and apply updates to revenue codes				
389.	Upload and apply updates to ICD-9 procedure codes				
390.	Upload and apply updates to State-assigned procedure codes				
391.	Upload and apply updates to ICD-9 diagnosis codes				
392.	Upload and apply updates to DSM codes				
393.	Upload and apply updates to NDC pharmacy codes				
394.	Upload and apply updates to NABP identification numbers				
395.	Upload and apply updates to CLIA numbers				
396.	Upload and apply updates to RBRVS				
397.	Upload and apply updates from or to State licensure files				
398.	Update codes for DRGs and RUGs				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
	State-defined rate tables including, but not limited to:				
399.	▪ Anesthesia base rates				
400.	▪ GBHC administration fee rate				
401.	▪ EPSDT schedules				
402.	Maintain Copay database				
403.	Maintain DRG tables including diagnosis codes and complications and comorbidities, based on client-assigned grouper				
404.	Maintain Provider type, category of service, and provider specialty codes				
405.	Maintain Fee schedules				
406.	Maintain a listing of and criteria for claims edits as prescribed by the State				
407.	HMO/MCO criteria–as deemed necessary by the state				
408.	Maintain Medical criteria				
409.	Maintain Usual and customary fees				
410.	Maintain Conversion Factor File (control file)				
411.	Maintain Place of service codes				

Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Reference File Maintenance Comments:				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Additional Reporting:					
412.	Ability to generate data extracts on request in multiple media, including but not limited to tape, diskette, CD-ROMs, FTP files				
413.	Provide data to the State to satisfy the SURS reporting requirement				
414.	Provide data to the State to satisfy the EPSDT reporting requirement				
415.	Provide data to the State to satisfy the Federal MARS reporting requirement				
416.	Ability to analyze the frequency, extent, and type of claims processing errors				
417.	Ability to monitor third party collections and avoidances				
418.	Ability to analyze provide claim filing for timeliness				
419.	Ability to analyze drug use for cost and potential abuse				
420.	Ability to provide geographic analysis of members, costs, and providers				
421.	Ability to prepare and monitor budget allocations by categories of service				
422.	Ability to project program costs based on past experience				
423.	Ability to compare current cost with previous period to analyze cash flow				
424.	Ability to analyze program expenditures to determine relative cost benefit				
425.	Ability to analyze member access to healthcare				
426.	Ability to analyze Medicare buy-in recipient data				
427.	Ability to track and report IBNR				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
428.	Ability to produce a payee ranking report				
429.	Provide data to the UM vendor, as required				
430.	Ability to produce a provider category of service ranking				
431.	Provide automated interface with HCFA for transmission of HCFA required reports				
432.	Provide MSIS (Medicaid Statistical Information System) reporting (HCFA-2082)				
433.	Produce HCFA 64 report as specified by the State				
434.	Provide data to actuarial contractor for rate analysis as specified by the State				
435.	Produce and distribute report of expenditures by COS, Aid Category and claim type.				
436.	Produce automated HCFA 372 report of waivered services and payments.				
	Utilization reporting subsystem to provide on-demand request to include, but is not limited to:				
437.	▪ Identify aberrant member usage patterns				
438.	▪ Identify under-utilization patterns				
439.	▪ Rank providers, members, and procedures by highest and lowest utilization				
440.	▪ Extracts by diagnostic and procedure codes for clinical studies				
441.	Claims processing statistics				
442.	Produce online summaries of financial system reconciliation				
443.	Ad hoc reporting and distribution system				
444.	Provide weekly summarized databases for ad hoc reporting				
445.	Provide monthly summarized databases for ad hoc reporting				
446.	Provide online ad hoc query tool				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
447.	Provide random number generator for sampling				
448.	Data extract feature for expenditure data requests				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
	Ability to extract data and format transfer files for upload into:				
449.	▪ Lotus 1-2-3				
450.	▪ MS-Excel				
451.	▪ MS-Access				
452.	▪ MS-Word				
453.	▪ Paradox or other database software				
454.	Ability to track and report on hospice services				
455.	Ability to track and report on home health services				
456.	Ability to track and report on mental health services				
457.	Ability to track and report on rural health center services				
458.	Ability to track and report FQHC services				
459.	Ability to track and report Crossover services				
460.	Ability to track and report services or groups of services as defined by user				
461.	Ability to track and report eligibility counts and trends by aid category				
462.	Ability to track and report utilization patterns by aid category and category of service				
463.	Support for user-defined category of service groupings				
464.	Ability to track and report expenditures by state and federal categories				
465.	Ability to track and report claim lag				
466.	Ability to aggregate data on seasonal patterns of illness				
467.	Summarize and capture quality of care issues				
468.	Provide data for review of hospitalization review plans				
469.	Provide recipient data statistics and unduplicated counts by program, demographics, geographic location, etc.				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
470.	Provide data on provider network as requested				
471.	Provide data and reports on cost avoidance as requested				
472.	Generate recipient letters as requested				
473.	Generate provider letters as requested				
474.	Provide data to calculate standard performance indicators as requested				
475.	Provide data extracts to vendors as requested				
476.	Generate reports detailing Hospital reimbursement				
477.	Generate reports detailing Nursing facility reimbursement				
478.	Ability to report on patient days at Nursing facilities				
479.	Provide statistical analysis on request				
480.	Provide statistical analysis tools				
481.	Provide forecasting tools				
482.	Generate report of exceptions to billed charges				
483.	Generate additional reports such as the Indigent Care Trust Fund (ICTF) Report to payments to hospitals				
484.	Provide for the reduction of a provider's payments by 31 percent for IPS Backup Withholding while still accounting for the total payment				

Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Additional Reporting Comments:				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Financial and Accounting Interface:					
485.	System must support accrual basis and cash basis accounting per Generally Accepted Accounting Principles (GAAP) or new Governmental Accounting Standards Board (GASB) standards, as appropriate				
486.	Provide automated interface between claims processing/claims payment subsystem and State accounting system				
487.	Perform automated bank account reconciliation (BAR)				
488.	Maintain federal tax information for all contracted providers				
	Ability to make payments not related to claims processing such as:				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
489.	▪ Disproportionate share hospital payments				
490.	▪ Nurse Aide Training Program payments				
491.	▪ Hospital cost settlement payments				
492.	▪ Prospective and retrospective rate changes				
493.	Ability to interface with TPL vendor				
494.	Ability to initiate EFT payment to providers, electronically				
495.	Ability to allow authorized DCH staff to enter payment requests				
496.	Ability to enter payment requests online				
497.	Ability to enter adjustment requests online				
498.	Ability to correct data on the "proof" run if errors are found				
499.	Ability to generate and submit check registers to DCH/BOR for review prior to wire transfer of funds to providers				
500.	Provide safeguards for all check deposits and receivables to ensure that only authorized changes can be made				
501.	Ability to receive and process electronic transfer of refunds from insurance companies				

	Matrix 2 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
502.	Ability to separate PeachCare and Medicaid member expenditures				
503.	Provide software for supporting 1099 preparation and magnetic media reporting according to IRS specifications				
504.	Produce on-demand duplicate 1099 forms				

Financial and Accounting Interface Comments:

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Matrix #3: SHBP/BORHP Requirements

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
FUNCTIONAL REQUIREMENTS					
Network Administration—Pertinent to the Indemnity Network and to the Retention of the Third Party PPO Network Data:					
1.	Maintain separate third party indemnity and PPO professional and facility networks for providers in Georgia, the National PPO Overlay, Transplant and Behavioral Health Preferred Networks, including international locations as applicable				
	Maintain various of provider classifications:				
2.	▪ Individual physicians				
3.	▪ Group practices				
4.	▪ Facilities (by type of service)				
5.	▪ Ancillaries (by type of service)				
6.	– Chiropractors				
7.	– Podiatrists				
8.	– Vision				
9.	– Dental				
10.	▪ Home health care				
11.	▪ Transplant				
12.	▪ Transportation, etc.				
13.	▪ Mid-level providers				
Network Administration Comments:					

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Retention of Provider Demographic Information:					
14.	Provider name, servicing address(es), billing address, phone, and other identification for each individual and multiple office location				
15.	Effective dates and renewal dates of contracts, current and prior two years				
16.	Current network participation status for each provider contract				
17.	License date, number, and state of issuance				
18.	Board certification status				
19.	Suspend payment indicator with reason code				
20.	Assigned region and area (including national or international regions)				
21.	Ability to link individual providers or groups of providers by tax ID number (TIN) to member records for in-network benefits at out-of-network providers pursuant to Georgia Consumer Choice Option law				
Retention of Provider Demographic Information Comments:					

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Network Administration Reporting:					
22.	Generation of product-specific provider directories for indemnity network by multiple sorting options (i.e., county, alpha order, specialty)				
23.	On-line query with print capabilities by provider type, specialty, location (zip code), ideally with map capability				
24.	On demand printing of directories by network, location, and provider type				

Network Administration Reporting Comments:

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Provider Network Management for Indemnity Network:					
25.	History of provider enrollment and termination dates				
26.	Generate reports and supporting documentation on demand to support BORHP and SHBP in provider grievance hearings and appeal processes				
Provider Network Management for Indemnity Network Comments:					

Provider Credentialling—Must Track for Indemnity Network:					
27.	Track any known periods of probation for providers in the indemnity network				
28.	E-mail capability of provider correspondence				
29.	Track dates of application and certification				
30.	Practice status of hospitals where provider has privileges				
31.	Activity tracking dates with user identification				
32.	Dates, places, and outcomes of medical training				
33.	Colleges and medical schools attended				
34.	Continuing medical education credits				
35.	Membership in professional societies				
36.	Malpractice coverage details				
37.	Lawsuit history				
38.	Details on negative actions of credentialling or certifying groups				
39.	Paraprofessionals in office and their function				
40.	Average number of hospital admits, consults, and census				
41.	Ancillary services in office (e.g., x-ray, certified lab, etc.)				
42.	Ownership in related ventures				
43.	Teaching appointments				
44.	Medical references				
45.	General description of practice				
46.	Accepting new patients (Y/N)				
47.	Office hours				
48.	Emergency coverage				
49.	Foreign language fluency				
50.	Appointment waiting time				
51.	Age/sex range limits on patients				
52.	Procedures performed in office				
53.	Track terminated providers and reason for termination				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
54.	Track providers who have applied but have been denied a contract				
55.	Track provider applications and contracts by multiple sorting options (e.g., by application date, recredentialing date, etc.)				
56.	Track provider types (MD, DO, Ph.D., Masters)				
57.	Integrate provider data with claims, provider profiling, etc.				

Provider Credentialing Comments:

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Eligibility and Enrollment:					
58.	Ability to convert and replace current SHBP membership billing and accounting system (MEMS) for SHBP				
59.	Ability to interface with the BORHP PeopleSoft system to accept eligibility				
60.	Ability to generate plastic Health Benefit Plan Identification cards for SHBP and BORHP				
61.	Ability to generate Health Benefit Plan Identification swipe cards for SHBP and BORHP				
62.	Ability to generate HMO notification of member action through e-mail or facsimile				
63.	Accept web-enabled real time electronic enrollment				
64.	Accepts and automatically processes real time electronic eligibility updates				
65.	Performs duplicate checking and other system edits for member eligibility prior to allowing an add to the system				
66.	Accepts employer provided ID number (nine position) or can assign a unique ID number for employee/subscriber and for dependents (standard sequencing/suffix codes)				
67.	Maintains other insurance information				
68.	Maintains historical enrollment data				
69.	Maintains basic and customized member demographic information				
70.	Maintains separate address for subscribers and each dependent				
71.	Records free form comments or remarks				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
72.	System has the ability to match or reconcile number of employee contracts in the vendor system to the originating eligibility systems of record (PeopleSoft/MEMS replacement)				

Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Eligibility and Enrollment Comments:				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Membership and Eligibility—Termination/Conversion:					
73.	Integrated membership database that interfaces with other system components (e.g., claims processing) to assure that all functional areas have updated membership data				
74.	Accept terminations for subscriber and dependent members or dependents only				
75.	Automatic generation of letters/e-mail to over age dependents and support automatic termination of dependents based on lack of response				
76.	Termination of dependents automatically when subscriber changes to individual coverage				
77.	Automatic termination of all subscribers and dependents when group contract is terminated				
78.	Allow retroactive terminations with appropriate financial controls				
79.	Can support an automated regularly scheduled COBRA eligibility update from Third Party Administrator				
80.	Supports automated compliance with HIPAA certification letter requirement				
81.	Retention of administrative and demographic data of terminated members and groups for seven years				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
82.	Can support surviving spouse coverage and automatically links claims history				
Membership and Eligibility—Termination/Conversion Comments:					
Membership and Eligibility—Reinstatement:					
83.	Generate administrative fee billing adjustments for retroactive reinstatements				
84.	Ability to reinstate members on an individual or group basis with no lapse in coverage				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Membership and Eligibility—Reinstatement Comments:					
Membership and Eligibility Electronic Reporting:					
85.	Generate enrollment reports to at least three levels of delineation (i.e., group, subgroup, product)				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
86.	Termination lists with reasons and summary totals				
87.	New member lists with various breakdowns and summaries				
88.	Transfers with totals and reasons				
89.	Member month totals by month, including retroactivity				
90.	Ability to generate monthly billings to employers				
91.	Ability to generate monthly COBRA billings for SHBP (and BOR if requested)				
92.	Ability to generate other self-pay billings				
93.	Ability to create receivables record for each billing record generated				
94.	Ability to generate personalized correspondence for events such as Loss of Dependent eligibility				
95.	Ability to submit monthly enrollment files to the DSS vendor				
Membership and Eligibility Electronic Reporting Comments:					

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Membership Distribution and Analysis Reporting by:					
96.	Age				
97.	Location				
98.	Age/sex category				
99.	Group				
100.	Contract type/Plan type (i.e., PPO, Consumer Choice Option(s), indemnity, or HMO)				
101.	Coverage type				
102.	Age of account				
103.	SIC				
104.	Employee breakout (employee, employee +1, employee + family, etc.)				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Membership Distribution and Analysis Reporting Comments:					
Administrative Expense Reports:					
105.	Year-to-date monthly administrative fee charges and payments to three levels of delineation (i.e., group, subgroup, product/plan)				
106.	Ability to itemize ad hoc expenses separately from PEPM administrative fees				
107.	Report adjustments and other claims expense reconciliations separately from paid claims				
108.	Ability to reconcile PEPM administrative fees paid against expected based on eligibility file records				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Administrative Expense Report Comments:					
Claims System Utilization Controls:					
	System automatically supports customized medical management protocols, including length of stay tables and criteria:				
109.	▪ By payer				
110.	▪ By plan				
111.	▪ By procedure (i.e., transplants)				
112.	System automatically verifies member eligibility				
113.	System automatically validates place of service				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
114.	System automatically verifies service appropriateness based on diagnosis, sex, age				
115.	System automatically verifies assistant surgeon necessity				
116.	System automatically verifies appropriateness for outpatient/office procedures				
117.	System automatically verifies medical necessity protocols/algorithms				
118.	System automatically verifies coverage based on procedure				
119.	System automatically verifies diagnosis/procedure-specific LOS tables				
120.	System provides automated support for care management standards varied by product				
121.	System automatically verifies appropriateness of procedure based on diagnosis				
122.	System automatically validates pre-certification authorization against submitted claims (define system edits)				
123.	System automatically supports validation of provider licensure to perform services				

Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Claims System Utilization Controls Comments:				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Preauthorization:					
	Identify services requiring preauthorization based on:				
124.	▪ SHBP or BOR Plan design or product				
125.	▪ Dollar amount of claim				
126.	▪ Type of service				
127.	▪ Diagnosis				
128.	▪ Other				
129.	▪ Provider status (par or non-par)				
130.	▪ Procedure				
131.	▪ Provider place of service				
132.	▪ Age				
133.	▪ Sex				
134.	Electronic interface with third party utilization management firm for the acceptance of preadmission certifications (PAC records) and other services requiring authorization				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Preauthorization Comments:					
Support Disease Management Initiatives:					
135.	Target high dollar and high incidence diseases and conditions by diagnosis, DRG, ICD-9, etc.				
136.	Electronically report **all** populated UB-92 or HCFA 1500 claims and provider data				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Support Disease Management Initiatives Comments:					
Claims Interfaces:					
137.	Ability to accept claims via electronic media (list interfaces in comments section below)				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
138.	Ability to accept claims via electronic interfaces with third party vendors (network managers and mental health vendors, etc.)				
139.	All third party data entry and/or record retention (imaging, scanning, microfilming) arrangements have an automatic interface for claims entry into the claims system				
Claims Interfaces Comments:					
Claims Processing:					

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
140.	Automated imaging/OCR technology for paper claims processing				
141.	Batch mode processing if necessary				
142.	Ability to enter partial header data without complete claims information				
143.	Ability to customize EOBs				
144.	Pay multiple member claims on a single EOB				
145.	Accept and process claims from super bill containing multiple services				
146.	System supports modifiers for HCPCS codes				
147.	System security to support “dollar step limit draft authority levels” for individual claims adjudicators				
148.	System security that supports the setting of processor dollar limitations as well as limitations by specific claim functions and benefit plans				
149.	Accept, retain, and use all five positions of ICD-9-CM or later versions whenever diagnostic coding is used				
150.	Accept and capture **all** data fields submitted via HCFA 1500, UB92, and ADA claim forms				
151.	Calculate, adjust claims, and track recovery of dollars, whether overpayment recovery is performed internally or under contract by a specialized third party				
152.	Execute payment claims; payment cycles weekly or biweekly as specified by BOR				
153.	Interface with State/BOR financial reporting system				

Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Claims Processing Comments:				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Claims Pricing:					
154.	Performs the automatic pricing and adjudication of claims using an RBRVS-based fee schedule				
155.	Performs the automatic pricing and adjudication of claims using a percent discount off charge discount arrangement				
156.	Performs the automatic pricing and adjudication of claims using a specific fee schedule				
157.	System automatically pays DRG reimbursement methodology based on client-assigned grouper				
158.	System edits identify duplicate DRG payments on the date of admission (e.g., to avoid duplicate payments for a patient who transferred within the same facility)				
159.	Performs pricing of each claim line item by incurred date				
160.	Claims unbundling software integrated into claims system and applied to all provider claims				
161.	Price claims with multiple items of service by line item				
162.	Ability to process a claim on a line-by-line basis				
163.	Ensure all dates are valid and reasonable (i.e., no futures dates are present)				
164.	Ensure that all items that can be obtained by arithmetic manipulation of other data items agree with the results of the manipulation (cross footing and totals)				
165.	Ensure all coded data items (procedure, diagnosis, place, type, units, modifier) consist of valid codes				
166.	Provide data to actuarial contractor for rate analysis as specified by the SHBP/BOR				

Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Claims Pricing Comments:				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Automatically Calculate and Compare:					
167.	System automatically verifies all mandatory data items are present and accurate				
168.	System automatically verifies the services requiring prior authorization; system automatically matches services to the appropriate authorization				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Automatic Calculation/Comparison Comments:					
Deductible and Benefit Limits:					
169.	Initialize deductible and benefit limit counts when new contracts become effective				
170.	Support carry-over of deductibles from prior coverage				
171.	Track hospital day benefit limits separately by bed type/service				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
172.	Allow override to benefit limits during claim adjudication with appropriate audit trail tracking				
173.	Allow benefit limits to be adjusted online as an exception with appropriate audit trail tracking reporting				
174.	Accumulate out-of-pocket amounts, benefit limits, and deductibles for a member or family in aggregate or individually by benefit classification				
175.	Differentiate PPO/non-PPO accumulators on a contract year and lifetime basis				
176.	Automatic handling of copays, application of deductibles, and percentage reductions per line item				
177.	Accumulation of lifetime maximum amounts on an individual member basis				
178.	Exclude specified service types from accumulation of deductibles, stop loss, and lifetime maximums				
179.	Supports multiple deductibles (general vs. hospital admission; in-network versus out-of-network)				
180.	Supports selective benefits towards a deductible or other form of cost share				
181.	Supports selective benefits towards the out-of-pocket maximum				
182.	Support a deductible carry-over concept				
183.	Load 2003 and 2004 coinsurance, copayment, out-of-pocket maximums, and lifetime maximum accumulations from current TPA				
184.	Automatically adjudicate claims based on load of 2000 and 2001 accumulators from current TPA				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Deductible and Benefit Limit Comments:					
Miscellaneous Functions—Interfaces with UM Vendor:					
185.	Supports standards for exchanging eligibility data electronically				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
	with UM vendors at a minimum on a batch basis				
186.	Supports standards for exchanging authorizations data with UM vendors at a minimum on a batch basis				
187.	Supports standards for exchanging claims data with UM vendors on a batch basis (for profiling purposes)				
188.	Supports standards for exchanging eligibility data electronically with UM vendors on an interactive basis				
189.	Supports standards for exchanging authorizations data electronically with UM vendors on an interactive basis				

Miscellaneous Functions—Interfaces with UM Vendor Comments:

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Utilization Management Reporting:					
190.	Ability to track and report services provided by BOR's dental indemnity program with BCBSGA				
191.	In addition to the specific reports and measures listed below, the general ability through ad hoc reporting tools to report on any element from the medical claims database				
	All utilization measures severity indexed by:				
192.	▪ Diagnoses				
193.	▪ Comorbidities				
194.	▪ Age				
195.	▪ Sex				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Utilization Management Reporting Comments:					
Customer Service Systems:					
196.	Electronic communications and tracking log providing access to third party vendors to interface with claims administrator				
	ACD telephone system that provides both management and client reporting of telephone statistics and department performance. These statistics should include:				
197.	▪ Telephone volumes by client				
198.	▪ Telephone volumes by specific time period				
199.	▪ Telephone volumes by CSR				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
200.	▪ Average wait time				
201.	▪ Abandonment rate				
202.	▪ Average speed of answer				
203.	▪ Average length of call				
204.	▪ Busy out rate				
205.	Ability to off-load calls to trained staff during high volume call periods				
206.	Ability to identify percent of "first call resolution" and those requiring research and to track and report this information to client				
207.	Dedicated customer service unit to support client telephone inquiries/dedicated toll-free separate telephone lines for SHBP, SHBP Retirees, and BORHP				
208.	Tracking system to record and report all telephone calls received for client and to identify the reason for the call, the resolution of the call, and any call-back or follow-up actions required				
209.	Produce daily, weekly, and annual tracking and analysis reports				
	Ability to report statistics by Customer Service Representative (CSR) by:				
210.	▪ Time in available				
211.	▪ Time in unavailable				
212.	▪ Average talk time				
213.	▪ Number of calls taken				
214.	Automated call routing				
215.	An interactive voice response function to assist callers in accessing the appropriate department/services (note that the BOR will continue to have live individuals available to assist				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
	members at all of its vendors)				
216.	Toll free lines available statewide/nationwide				
217.	Ability to record and store all customer service calls for up to 60 days with ready accessibility to records				
218.	Online supervisory call monitoring				
219.	Online real-time system monitoring by plans in-house				
220.	Automatically track and report at least daily performance against expected contractual performance standards (percent calls answered in 30 seconds, abandonment rate, busy-out rate, first call resolution)				
221.	Ability to immediately post and change recorded messages in the VRU system				
222.	Provide a telephony system that is capable of taping conversations between service reps and members with the ability to send .WAV files to the DCH/BOR for review if requested				
223.	Scheduler ability allowing identification of high/low volume periods of time				
	Online documentation and tracking of all calls received from providers and members including, at a minimum:				
224.	▪ Name				
225.	▪ Receipt date				
226.	▪ Type				
227.	▪ Response action				
228.	▪ Response date				
229.	Ability to record and store all customer service calls for up to two years, with ready accessibility to records				
230.	Ability for offsite monitoring of the system				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
231.	Automatically track and report at least daily performance against expected contractual performance standards (percent calls answered in 30 seconds, abandonment rate, busy-out rate, first call resolution)				
232.	Ability to increase incoming call capacity if needed within 24 hours or less				
233.	Voicemail for CSRs/Electronic Mail for CSRs				
Customer Service Systems Comments:					
Customer Service/Grievance Reports:					
234.	Complaints by user-defined criteria				
	Performance measure reporting by:				
235.	▪ Average days to resolution				
236.	▪ Complaints resolved prior to grievance				
237.	▪ Number of complaints resolved in first contact				
238.	▪ Open complaint report				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
239.	▪ Complaints by provider and reason				
240.	Standardized coding and menus to capture problems, actions and notes				
241.	Auto-generated correspondence based upon problem and action				
Customer Service/Grievance Report Comments:					
Customer Service/Grievances:					
242.	Contact logging and documentation system				
243.	Tracking of issue resolution				
244.	Flag system for follow up				
245.	Online inquiry to enrollment files				
	Manage resolution of claims, utilization management,				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
	management, provider, and member issues, including:				
246.	▪ Provider claims status questions				
247.	▪ Member and/or provider benefit plan questions				
248.	▪ Provider administrative requirements questions				
Customer Service/Grievances Comments:					
System Maintenance:					
249.	Ability to add and delete users				
250.	Ability to modify security access levels on individual users				
251.	Ability to assign passwords				
252.	Ability to add printers and other hardware to the network				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
253.	Ability to load new tables such as fee schedules or rates (i.e., updated CPT-4 codes)				
254.	Ability to add new codes to an existing field				
255.	Ability to modify field edits				
256.	Ability to modify standard notice text				
257.	Ability to modify variable notice text				
258.	Ability to modify an existing report				
259.	Ability to support ongoing system maintenance				

System Maintenance comments:

FUNCTIONAL CAPABILITIES

Provider Compliance and Status Tracking Indicators for Indemnity Network:					
260.	Malpractice coverage				
261.	Submission of references				
262.	Sanctions and history				
263.	QA review standards				
264.	Accessibility criteria				
265.	Training standards				
266.	Professional affiliations				
267.	Hospital and outpatient affiliations and privileges				
268.	Professional coverage requirements				
269.	Board and other certifications				
270.	Practice requirements				
271.	User-defined pass/fail criteria				
272.	Provider compliance to administrative and utilization management requirements				

Provider Compliance and Status Tracking Indicator Comments:

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Claims Processing:					
273.	Ability to enter information such as temporary address changes at claims entry				
274.	Automatically distribute work to processors based on security and/or proficiency levels				
275.	Automatically retrieve pended/suspended claims for processing after corrections				
276.	System has built-in controls for processing claims in batches				
277.	System automatically applies age and sex edits based on claim and enrollment data				
278.	Stores system descriptions, full and abbreviated, of all procedure codes				
Claims Processing Comment					

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Claims Pricing:					
279.	System automatically applies DRG outlier limits, including short stays and readmissions				
280.	Accommodate multiple pricing methods by provider, area, or product				
281.	Ability to price services by provider type				
282.	Automatically price second and subsequent surgeries performed on same day				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Claims Pricing Comments:					
Automatically Calculate and Compare:					
283.	Appropriate fee level				
284.	Amount allowed				
285.	Amount not covered				
286.	Applicable co-payment				
287.	Applicable deductible amount				
288.	Facility (DRG, percent off charges) discount amount				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
289.	Applicable stop-loss amount				
290.	Net amount to be paid				
291.	Applicable coinsurance amount				

Automatic Calculation/Comparison Comments:

Deductible and Benefit Limits:					
292.	Support the concept of a deductible per admission or per occurrence, with or without associated maximums				
293.	Support copays for a given number of services, with subsequent services of the same type having a percentage reduction in payment amount applied				
294.	Automatic application of annual lifetime maximum restoration amount				
295.	Permit a waiver on deductibles for certain common accidents				
Deductible and Benefit Limit Comments:					

Quick Access Support:					
	Real-time access to the following data without losing claims information already entered:				
296.	▪ Eligibility data				
297.	▪ Contract data				
298.	▪ Benefits data				
299.	▪ Claims history				
300.	▪ PCP history				
301.	▪ Diagnosis information				
302.	▪ Procedure information				
303.	▪ Provider files				
	Allow the ability to access by:				
304.	▪ Audit control number				
305.	▪ Dependent number				
306.	▪ Provider number				
307.	▪ Subscriber number. Note that Georgia Code may change and require that the subscriber number be different from the SSN. If this occurs, the system must be able to track subscriber ID and dependent/spouse ID back to the subscriber/spouse/dependent SSN				
308.	▪ Dependent SSN				
309.	▪ Subscriber SSN				
310.	▪ Check number				
311.	▪ Provider name				
312.	▪ Processor				
313.	▪ Subscriber name				
	Ability to delimit claims search by:				
314.	▪ Defining claim type				
315.	▪ Defining date ranges				

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
316.	▪ By member only or entire family				
317.	▪ Capture, store, and edit for limit value				
	Use of "ENCODER" software to support translation to appropriate code, and maintain reference files for:				
318.	▪ CPT				
319.	▪ ADA				
320.	▪ NDC				
321.	▪ UB 82/92				
322.	▪ HCPCS				
323.	▪ ICD-9				
324.	▪ ICD-10				

Quick Access Support Comments:

Subrogation, Workers Compensation, and COB Cases:					
325.	Automatically process primary and secondary benefits for member with dual coverage with same or other employer				
326.	Automatically check every claim to identify cost avoidance or post-payment recovery procedures				
327.	Produce necessary reports and notifications				
328.	Prompt the processor to indicate whether the claim is accident related and track date of injury				
329.	Where COB amount is known, adjust claim amount appropriately				
330.	Automatically process dual Medicare coverage				
331.	Automatically verify that each claim is checked against all current and previously processed claims for which duplicate payment could exist as both an exact duplicate or suspected duplicate				
Subrogation, Workers Compensation, and COB Comments:					
Query Functionality:					

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
332.	Alpha diagnoses/procedures look-up				
333.	Code finder look-up of procedures/diagnosis				
334.	Diagnosis/procedure code conversion				
335.	Hot key/fast transfer to other applications				
336.	Pend for medical review/print review worksheet				
337.	Track progress of multiple levels of approval				
338.	Authorization number				
339.	Referring provider				
340.	Member number/name/SSN/ID number				
341.	Subscriber name/ID/SSN				
342.	Date authorized				
343.	Referred-to provider				
344.	Facility				
345.	Diagnosis				
346.	Procedure				

Query Functionality Comments:

	Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Correspondence:					
347.	General text editing online				
348.	Full word processing integrated with database				
349.	Automatic download of subscriber and member addresses into document				
350.	Track the status of incoming member correspondence on the same file as telephone and other inquiries				
351.	Complaint/communication type code assignment				
352.	Form letters with modification capability				
353.	Automatic generation of correspondence/e-mail based on events or time passage				
354.	Library of form letters/e-mails integrated with database				

Matrix 3 System Requirement	Current System Capability	Future System Capability	Manual Process	No Capability
Correspondence Comments:				